bro-spinal character may or may not be evident. Some cases seem to be cerebral, some spinal.

The relation of psychoses to syphilis is obscure. Maniacal and melancholic mental states, or dulness and sleepiness, merging into dementia, are ordinary clinical expressions of organic brain syphilis. Can these be distinguished from functional cases? The writer believes that there are a few cases in literature which indicate that a diagnosis of syphilis can be made in these cases, and a direct antisyphilitic treatment give benefit. Post-syphilitic dementia is in all probability due to vascular disease. In most cases of syphilitic mania, meningitis, or vascular disease, could be demonstrated. W. B. NOYES (New York).

DORMIOL IN EPILEPSY. J. HOPPE (Münchener med. Wochenschrift, April 29, 1902).

Dormiol has been used in eleven cases of status epilepticus, and it has been found that, so far as efficiency is concerned, it ranks equally with amylene hydrate, and has not any after-effects. The administration was per rectum in the form of two to three tablespoonfuls of a stock solution, 10 to 150, in from one-quarter to one-third liter of water. For continued use in epilepsy, dormiol is no more suited than is chloral or amylene hydrate, except, perhaps, in certain cases of epilepsia nocturna. In cases of epileptic confusion, with motor restlessness, it failed completely. JELLIFFE.

PHOTOTHERAPY AND NEURASTHENIA. P. JOIRE (La Semaine Médicale, 1902, No. 17).

The important modifications which one notes in the nervous system following the use of colored rays of light, or of decomposed light, induced this author to employ phototherapy in treating neurasthenic troubles. In his experience the red rays are especially to be recommended for this purpose, not only because of the sedative effects which they appear to produce upon the nervous system, but also because of their considerable power of penetration and of regulation exercised upon the blood circulation. The treatment by red light is particularly efficacious in cases of hyperesthesia, which constitutes, as is well known, the point of departure of most of the characteristic symptoms of neurasthenia, such as headache, vertigo, pain in the back, etc. In cases in which one sees, after the disappearance of painful symptoms, a certain degree of cerebral depression, it will be well to employ light cures of other orders, and to make, according to the state of the patient, a variation of color and intensity and manner of application. The calming action of phototherapy, and especially of exposure to red rays, seems also to have the power of increasing the strength of the patient, augmenting the appetite, regulating digestion, and governing general nutrition. In spite of their great susceptibility, neurasthenics undergo treatment with red light without difficulty, perhaps because the vibrations of this color are comparatively slow. JELLIFFE.

MULTIPLE NEURITIS. DANIEL R. BROWER (Medical Record, June 21, 1902).

The disease is the result of one kind of poison, and while the action of this agent may be limited to the peripheral portion of the neurone, yet there are cases in which the cell-body as well is impaired. The principal poisons producing multiple peripheral neuritis, are alcohol, lead, arsenic, and the toxine of various micro-organisms, especially those that produce diphtheria, influenza, typhoid fever, gonorrhea, syphilis, leprosy, and beri-beri. In the typical cases there is a symmetrical localization of motor, sensory and vasomotor symptoms. In earlier stages the symptoms are the result of irritation of the nerve, in the later of destruction. Different cases vary in developing one set of these symptoms, lead paralysis, Landry's paralysis and tetany being distinctly motor; pseudo-tabes and leprosy being sensory; and erythromelagia and Raynaud's disease being vasomotor in clinical type. The commonest form of multiple neuritis arises from alcoholism, and ordinarily presents a mixed type. Its diagnosis is based upon such evidences of chronic alcoholism as indicated by digestive, circulatory and nervous systems. The onset is insidious; the earlier symptoms are numbness and tingling, cramps and tremors, with painful symptoms and cutaneous anesthesia a little later, and sometimes a muscular hyperesthesia. The paralysis soon results in quadriplegia, with toe and wrist-drop, sometimes there is at first an exaggeration of the knee-jerk, followed by a loss of knee-jerk. Progressive atrophy occurs. Marked psychical disturbance sometimes occurs, due to the alcoholism.

W. B. Noyes (New York).

Clinical Differentiation of Brain Syphilis and General Paresis. W. A. M'Corn (Brooklyn Medical Journal, February, 1902).

The writer reports a case with the following symptoms: A capable business man, after a week of general apathy, headache, and insomnia, becomes incoherent, irrational and appears greatly confused and stupid. The muscular coördination becomes so marked that it is nearly impossible for him to walk, talk or care for himself in any way. He had had syphilis three years before. Examination of pupils was negative, the knee-jerks exaggerated, no fibrillary tremor of the tongue or face; facial expression dull and apathetic. Romberg symptom extreme. No grandiose ideas, memory poor for recent events. Owing to his unsteadiness on his feet he was put to bed and treated antisyphilitically. The patient improved for a short time. Three months after admission a divergent strabismus of the right eye, with ptosis, developed. Almost simultaneously the patient became somewhat filthy, mentally dull, and stupid. The diagnosis of paresis was made by eminent specialists, but is disputed by the writer, for the following reasons: Brain syphilis follows infection closely, from one year to ten. Paresis has a remoter syphilitic origin, and seems to be more the result of a parasyphilitic toxin. Mental stress is as essential a factor in paresis as heredity is insignificant. The course of the two affections shows a marked difference. In paresis it is slowly, but regularly progressive, the course of brain syphilis is extremely erratic. A degree of dementia out of all proportion to the duration of the disease is often followed by sudden and rapid improvement, to again lapse into a stupid, apathetic state similar to that found in the last stage of paresis. There is a wide difference in the mental symptoms, other than the intellectual defect. Paretics, as a rule, have a marked euphoria from the onset of the disease, accompanied by absurdly extravagant delusions, while the syphilitic is more depressed, and has hypochondriacal, melancholic delusions.

The physical symptoms of syphilis point almost invariably to focal and more or less limited lesions, while in paresis, to a diffuse involvement. General, tremulous and ataxic movements are not common to syphilis; the speech disturbances are not pronounced, and the headache in syphilis is persistent, diffuse, worse at night; while in paresis it is usually paroxysmal and localized. Optic neuritis is common in syphilis.

W. B. Noyes (New York).